STEP ONE: VOLUNTARY TREATMENT PROGRAM APPLICATION

ND DEPARTMENT OF HUMAN SERVICES
CHILDREN'S MENTAL HEALTH PROGRAMS
SFN 507 (04-2002)

PRIVACY STATEMENT: The Privacy Act of 1974 (P.L. 93-579, Section 7) requires the following to be provided when individuals are requested to disclose their social security numbers. Disclosure of the social security number is voluntary and it is requested for identification purposes. Failure to disclose this information will not affect participation in this program.

IMPORTANT INFORMATION: PLEASE READ!

Please complete this application as the first step in determining if the voluntary treatment program is an option for your child. This process includes a review of child protection, juvenile justice, community-based services accessed, psychiatric involvement, custodial arrangement, and Medicaid coverage regarding your child/children.

IDENTIFYING INFORMATION

Name of Child: First Last	Child's Date of Birth:	Child's Social Security Number:	
Address: (Street)	City:	State:	Zip Code:
Child's Medicaid Number:	Home Telephone Number:		
Current Living Situation:			
Medicaid Eligibility Worker:		Telephone Number:	
Planned Treatment Facility:	Other Insurance: If so, what Company?		

PARENTAL INFORMATION

Name: First Last	Marital Status:	Legal Custody Status:	
If Not Living with Child, Status of Contact with Child:			
Address: (Street)	City:	State:	Zip Code:
Work Telephone Number:	Home Telephone Number:		
Name: First Last	Marital Status:	Legal Custody Status:	
If Not Living with Child, Status of Contact with Child:			
Address: (Street)	City:	State:	Zip Code:
Work Telephone Number:	Home Telephone Number:		

*If the parental rights of a parent have been terminated, please provide a copy of the termination papers. Unless parental rights have been terminated, both parents need to agree to the use of this program, unless otherwise indicated by Department of Human Services.

Have you or either parent and the children lived in another state? ☐ Yes ☐ No
Please explain when and where:

OTHER SIBLINGS

Names:	Ages:
Names:	Ages:

COUNTY SOCIAL SERVICES INVOLVEMENT

Do either parent have a history of abuse or neglect towards their child/children where social services was involved? ☐ Yes ☐ No	Please Explain:
Have any children in this family been placed into foster care in the past? ☐ Yes ☐ No	Please Explain:
Is any member of this family currently involved with a social service agency? (Do not include economic assistance programs) ☐ Yes ☐ No	Please Explain:

JUVENILE JUSTICE INFORMATION

Has the child been adjudicated, delinquent, unruly, or deprived by a formal hearing in a juvenile court? ☐ Yes ☐ No	Please Explain:
Type and Year of Court Involvement:	
Is the child seeking out of home treatment currently involved with a juvenile court system? ☐ Yes ☐ No	Please Explain:

COMMUNITY BASED SERVICES

List the services used prior to considering out of home treatment services:
What symptoms continue that require out of home treatment?
What is the current DSM-IV Diagnosis?

CARE COORDINATION/CASE MANAGEMENT

Are you and your child/children involved with the Partnerships program, other public agency or affiliated agency who provides intensive care management to access needed services for the child to transition back into your home? ☐ Yes ☐ No	
If not, are you willing to become involved? ☐ Yes ☐ No	
Comments:	
Name of Current or Potential Care Coordinator/Case Manager:	Telephone Number:

PSYCHIATRIC INVOLVEMENT

Name of Psychiatrist Involved:		Telephone Number:	
Address: (Street)	City:	State:	Zip Code:
Is psychiatrist recommending this placement for treatment of the child? ☐ Yes ☐ No			
Is a written psychiatric recommendation attached? ☐ Yes ☐ No	Please indicate when it will be received:		
Comments:			

CERTIFICATION:

We/I hereby make application to the North Dakota Department of Human Services for the voluntary treatment program for my child.

We understand that this voluntary treatment program application process involves several steps to determine if the sole reason for placement is the need to obtain treatment services for a child's emotional or behavioral problems and includes the following:

- A review of past or current involvement with in or out-of-state child welfare system(s) with any of my/our children,
- A review of past or current involvement with the juvenile justice system,
- A review of past or current involvement with community based services,
- A required written recommendation from a psychiatrist indicating the need for this level of service,
- Verification that the child indicated is a Medicaid recipient.
- Verification that the child has a serious emotional disturbance.
- Signed multi agency release of information.

If approved for this program, we/I understand that:

- We/I need to be involved with the Partnerships program or other approved case management system that is prepared to provide intensive service coordination,
- We/I will need to enter into and abide by a legal agreement with the Department of Human Services and the signatures of both parents of the child are required on this agreement unless the Department of Human Services indicates otherwise,and
- The Medicaid eligibility worker will be informed of your child's involvement in this program.

We/I certify that the information in this application is true to the best of my knowledge and I/we grant permission for this information to be verified with the appropriate persons or agencies.

Parental Signature:	Date:	Parental Signature:	Date:

* Please include a signed multi agency Release of Information with this application.